DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAY 30 1986

From Richard P. Kusserow
Inspector General

OEO:FYI
cc:WRoper, HDesmarais, AAPD
AAO, AAM, AAEA, Spiegel
FJones, BERC

Subject OIG Final Report: "Medicare Cataract Implant Surgery" - OAI 85-IX-046--INFORMATION

To William L. Roper, M.D.
Administrator
Health Care Financing Administration

HCFA/EXEC.SEC.
JUN 4 PM 9:08

Attached is our final inspection report entitled, "Medicare Cataract Implant Surgery." In this inspection we found that hospitals receive much more for outpatient cataract surgery than ambulatory surgical centers (ASC); professional fees paid to the primary surgeons, assistants at surgery, and anesthesiologists seem too high; and the amount paid for intraocular lenses (IOLs) is excessive. To address these issues, we recommended that HCFA limit payments to hospitals to the amount paid to ASCs for cataract surgery, limit payments for IOLs, and establish an independent commission to assess the changes in surgical procedures and technology. Our final report incorporates comments made by HCFA on January 21, 1986.

We are extremely pleased that HCFA moved rapidly to issue a Medicare Carrier Manual instruction to limit reimbursement for IOLs. We are also supportive of the HCFA initiatives aimed at specifying special reasonable charge limits for these and other overpriced prosthetic devices. The Consolidated Omnibus Budget Reconciliation Act includes our recommendation that an independent commission be established to periodically assess the changes in surgical procedures and technology and prohibit routine reimbursement to assistants at surgery for routine cataract surgery. We understand that HCFA is moving to curtail excess outlays for anesthesiology with policy changes that may be forthcoming after the proposed inherent reasonableness rules are implemented.

We continue to believe that HCFA should establish Medicare policies which will provide an equivalent reimbursement for facility expenses no matter whether outpatient surgery is performed in a hospital or in an ASC. We recognize that existing ASC rates have not been updated in over 3 years and may not serve as an appropriate limit to apply to hospital outpatient surgery at this time. However, we support any initiative including a prospective payment method for outpatient surgery which fosters the goal of eliminating the existing reimbursement inequities.

If you would like to discuss our report in greater detail, let me know or have your staff contact Barry Steeley on (FTS) 934-5034.

Attachment

(1) Stacy Tunell + Staff
(2) Guests.

Date

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REMARKS

Attached for your information is a copy of the OIG's Final Audit on Medicare Cataract Implant Surgery.

The OIG has not requested comments from HCFA on their final report. Barry Steeley, OIG, is the contact person should you or your staff wish to discuss the report in greater detail.

DO NOT use this form as a RECORD of approvals, concurrences, disposals, clearances, and similar actions

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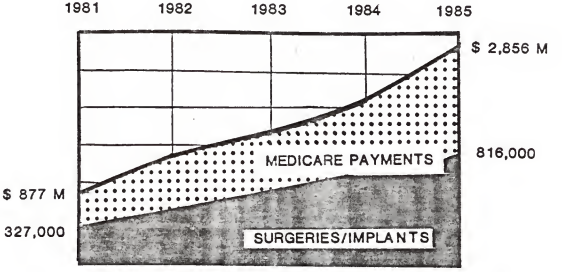
MEDICARE
CATARACT IMPLANT SURGERY



NATIONAL PROGRAM INSPECTION
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH & HUMAN SERVICES

MARCH 1986

OFFICE OF INSPECTOR GENERAL

This inspection was conducted under the leadership of the San Francisco regional office and its Seattle field office with assistance from the New York regional office.

The report was prepared by:

Paul Gottlober
Julie Bautista
John Daise
Wayne Wilson

With assistance from:

Barry Steeley

Headquarters Office
Washington, D.C.

Office of Analysis and Inspections, Region IX
March 1986

Control # OAI-85-IX-046

MEDICARE CATARACT IMPLANT SURGERY

INTRODUCTION

Within the past decade, cataract surgery (especially the implantation of intraocular lenses) has given many elderly restored vision, increasing their self-sufficiency and sense of well-being. Technical advances and widely-mastered surgical precision have combined to make this brief surgery remarkably effective with minimal risk to the patient.

Dramatic restoration of sight and near universal consumer satisfaction have created a demand which will result in almost one million cataract surgeries in 1985, and is projected to increase to two million by the year 1990.

Detracting from this success story are reports of fraud, waste and abuse which have tainted those involved: the manufacturer, the surgical facility and the ophthalmologist. The House Subcommittee on Health and Long Term Care projects that this will result in a loss to the taxpayer of almost $2 billion in 1985. This inspection, unlike the House Subcommittee report, does not address the issue of medical necessity of individual cataract surgeries. The Inspector General of Health and Human Services finds that Medicare is paying over $500 million each year in unnecessary costs, including discounts such as rebates and kickbacks that are not being passed on to the government. Overcharging for the lenses, inflating the costs of surgery and exorbitant mark-ups of facility fees are almost universal. In more human terms, it is sometimes the elderly Medicare beneficiary who is helping to subsidize the high incomes, perks and gratuities of the cataract surgery industry. This report identifies the significant factors involved and recommends measures that can be taken to prevent such losses in the future.

The specific purpose of this inspection is to: (1) determine what Medicare is paying for the components of cataract surgery (the facility, the lens and the professional practitioner), (2) identify the factors affecting costs and charges among hospital inpatient settings, hospital outpatient departments, ambulatory surgical centers and physicians' non-certified surgical suites, (3) assess the impact on beneficiaries and (4) determine how manufacturers and the forces of the market place are influencing services and expenditures.

This inspection is based on the results of a valid random sample of ophthalmologists who bill for intraocular lenses and a representative sample of surgical facilities. It was conducted in California, New York, Florida, Pennsylvania, Texas and Washington, where more than one-third of Medicare beneficiaries reside. Contacts included 46 hospitals and surgical facilities, 38 physicians, 50 ancillary staffs, 93 beneficiaries and their families and 5 of the 12 major lens manufacturers. Inspector General staff analyzed physician Medicare payment histories, patient medical and financial records, manufacturers' invoices and Medicare claims.

MAJOR FINDINGS

- SPECIALIZATION, VOLUME AND HIGH TECHNOLOGY IN CATARACT SURGERY HAVE MERGED TO GIVE SIGHT AND SELF-SUFFICIENCY TO THE ELDERLY.

- KEEN COMPETITION FOR MEDICARE PATIENTS HAS PRODUCED A WIDE-OPEN MARKET PLACE FOR AN EXPANDING 2.8 BILLION DOLLAR INDUSTRY.

- UNCHECKED, CATARACT SURGERIES WILL INCREASE TO 2 MILLION AND COST THE TAXPAYER NEARLY $6 BILLION BY 1990.

- THE MEDICARE PROGRAM AND BENEFICIARIES ARE PAYING MORE THAN NECESSARY—AT LEAST $500 MILLION MORE PER YEAR.

- MANUFACTURERS' INCENTIVES AND SALES PROMOTIONS ARE CONTRIBUTING TO EXCESSIVE COSTS.

- PROVIDERS, NOT MEDICARE, ARE BENEFITING FROM MANUFACTURERS' AGGRESSIVE PRICE CUTTING.

- SOPHISTICATED MARKETING SCHEMES BY THE INDUSTRY ARE COSTING THE ELDERLY AND MEDICARE MILLIONS.

- MEDICARE REIMBURSEMENT POLICY ENCOURAGES WIDE VARIATIONS IN THE COSTS OF LENSES, EQUIPMENT AND SURGERY.

- UNNECESSARY COSTS OCCUR BECAUSE MEDICARE:

  — PAYS DOUBLE OR TRIPLE THE PURCHASE PRICE FOR LENSES.

  — PAYS HIGH FEES TO ALLOW ANY PROVIDER TO PURCHASE HIGH TECH EQUIPMENT THAT COULD BE SHARED.

  — REIMBURSES HOSPITAL OUTPATIENT DEPARTMENTS UNDER THE "REASONABLE COST" SYSTEM WHICH ENCOURAGES INEFFICIENCY.

  — ALLOWS THE SERVICES OF OPHTHALMOLOGISTS, ASSISTANT SURGEONS AND ANESTHESIOLOGISTS TO BE BILLED AND PAID SEPARATELY.

  — PAYS FOR ASSISTANT SURGEONS AND ANESTHESIOLOGISTS ALTHOUGH LESS COSTLY BUT QUALIFIED AND PROFICIENT TECHNICIANS AND NURSES ARE AVAILABLE.

PROPOSED CHANGES

- LIMIT HOSPITAL OUTPATIENT FACILITY FEES AND BENEFICIARY CHARGES TO APPROXIMATE MEDICARE PAYMENTS AND CHARGES NOW AUTHORIZED FOR AMBULATORY SURGICAL CENTERS.

- ESTABLISH A NATIONAL CAP (BASED ON A GENERIC PRUDENT BUYER CONCEPT) FOR LENS PAYMENTS WHEN LENSES ARE BILLED SEPARATELY.

- PAY A SINGLE PROFESSIONAL FEE TO COVER ALL PROFESSIONAL STAFF ASSOCIATED WITH CATARACT SURGERY.

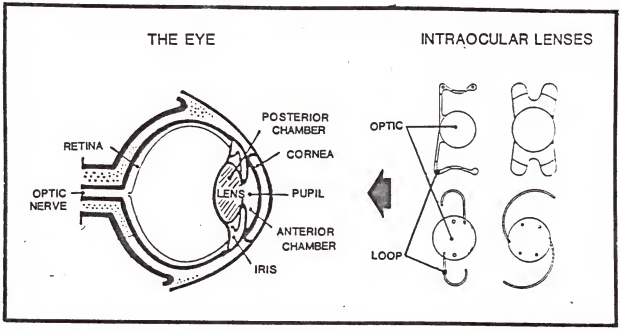
- CREATE AN INDEPENDENT COMMISSION TO ASSESS PERIODICALLY THE CHANGES IN SURGICAL PROCEDURES AND TECHNOLOGY AND MANDATE ADJUSTMENTS TO MEDICARE REIMBURSEMENT.

CATARACT SURGERY AND IOL IMPLANTS

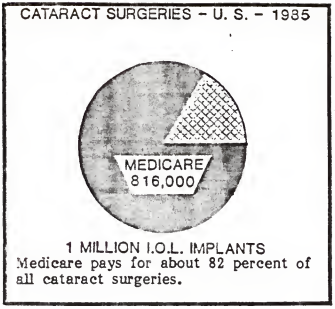
Immediately behind the pupil of the eye is the lens. Light passes through the lens and is focused on the inner back of the eye, or retina. The normal lens is clear. A cataract is a darkening of the lens. The lens changes in color from clear to black or opaque. When the lens is fully opaque, no light can pass through and the patient is totally blind.

The cataract condition can be corrected by surgically removing the lens and replacing it with a prosthetic lens. Prosthetic lenses include contacts, eyeglasses or surgically implanted intraocular lenses. An intraocular lens (IOL) consists of an optic portion which actually corrects the vision and an haptic, or loop, portion which secures the lens to the eye.

Most optics are made from a plastic, called PMMA, while the loops can be either PMMA or polypropylene. Lenses come in a variety of styles which are primarily distinguished by the loop configuration or material. Many lens styles are designated by the name of the ophthalmologist who designed the loop style; i.e., "designer lenses". Lenses are also available with added features such as ultraviolet filters or laser ridges.



The most commonly implanted lenses are positioned behind the pupil in the posterior chamber of the eye. When this cannot be done, an anterior chamber lens is used which is attached in front of the pupil and iris. Most providers maintain an inventory of both types of lenses in several styles and numerous strengths. The inventory frequently includes lenses from several manufacturers. The lenses are usually supplied on consignment so that providers only pay for the lenses when they are used.


CATARACT SURGERIES - U. S. - 1985
MEDICARE
816,000
1 MILLION I.O.L. IMPLANTS
Medicare pays for about 82 percent of all cataract surgeries.

Cataracts occur most commonly after the age of 50 and the Medicare aged population is the predominate receiver of cataract surgery. Although cataracts are the second leading cause of blindness, the condition rarely becomes an emergency. The decision of when to have surgery is normally left to the patient. The significance of improved vision for an individual to perform daily activities is a primary consideration. For example, the person with cataracts who fails a driving test can either choose surgery or discontinue operating an automobile.

CATARACT SURGERY CAN BE EFFECTIVELY PERFORMED IN EITHER AN OUTPATIENT OR INPATIENT SETTING

A dramatic shift in the setting for cataract surgery has occurred in the last year. The surgery, that historically involved an inpatient hospital stay of three to six days, can now be performed on an outpatient basis. Formerly the exclusive province of the hospital, the surgery is now frequently performed in ambulatory surgical centers and even doctor's offices. Significantly, hospitals themselves have been a part of this change in that surgery is now most frequently performed in the outpatient department of the hospital.

A combination of factors has hastened this trend. A major influence is the Professional Review Organization (PRO) which requires prior authorization for hospital stays associated with cataract surgery. Other factors contributing to this change include the reduced risk associated with the operation, technological advances in the surgical procedure, and Medicare prospective payment rates.

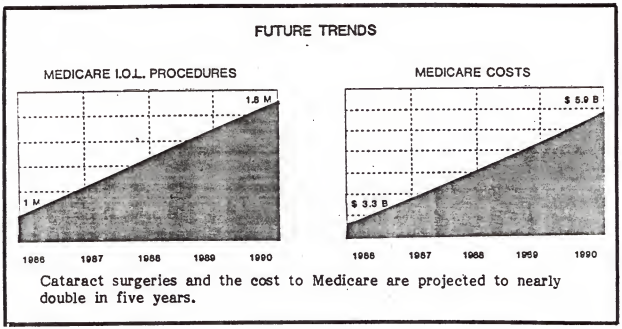
While a patient with severe coronary or pulmonary disease (or other life-threatening condition) may need inpatient hospitalization, ophthalmologists agree that routine cataract surgery can be performed in the outpatient department of a hospital or in an ambulatory surgical center. Some ophthalmologists are performing surgery in their own surgical suites, which are comparably equipped to surgical centers, but lack Medicare certification. Medicare certification assures that the facility meets safety standards and many of the ophthalmologists included in this inspection were in the process of obtaining Medicare certification for their surgical facilities.

The shift to the outpatient setting is a welcome development for Medicare beneficiaries who generally prefer being able to recuperate in their own homes and often dread the thought of a hospital stay. Professionals concur in this attitude from a gerontological standpoint, as it reduces the image of progressive disability associated with the aging process. Among beneficiaries there is widespread acceptance of having surgery in a free-standing ambulatory surgical center.

FUTURE TRENDS

INTRAOCULAR LENS IMPLANTS FOR CATARACT PATIENTS IS A GROWTH INDUSTRY

Lens manufacturers and market analysts predict that the number of cataract surgeries involving the use of intraocular lenses will continue to increase and may, in fact, double by the year 1990. For Medicare, this will mean an increase to almost 2 million surgeries costing almost $6 billion annually by 1990.



Cataract surgeries and the cost to Medicare are projected to nearly double in five years.

Many factors influence these projections, including the growing aged population, the trend towards cataract surgery on younger Medicare beneficiaries, and the success rate of the implant surgery itself. Also, there is less reluctance to undergo the surgery and cataract patients who have been wearing eyeglasses or contacts are now opting for intraocular lenses.

AN OBVIOUS TREND IS THE CONTINUED SHIFT OF SURGICAL SETTING FROM INPATIENT TO OUTPATIENT

There are some advantages for hospitals to encourage the move away from the inpatient setting, so long as the surgery is still performed at the hospital. Many hospitals have found that the payments under the Medicare prospective payment system have rendered inpatient cataract surgery unprofitable and that more Medicare revenue can be generated by the outpatient department.

As surgical procedures become less complicated and risky, many surgeons seize the opportunity to achieve more autonomy from hospitals. This incentive, coupled with the generally reduced intervention of health planning agencies, is expected to lead to the development of more surgeon-controlled ambulatory surgical centers where the physician is less dependent on the hospital and can receive payments for the facility as well as the surgery.

THE MARKETING OF CATARACT SURGERY

The marketing of cataract surgery and intraocular lens implants is determining the costs for Medicare and its beneficiaries. Cataracts are currently costing the government over $2.8 billion a year. This may double by 1990 if the increased demand for this surgery continues and the Medicare reimbursement does not change. The projected economic growth is the primary force behind an intense marketing strategy involving physicians, surgical facilities and manufacturers. Almost 30% of the elderly between 65 and 74 have impaired vision and are the target of an advertising blitz by hospitals and physicians. This is the first time a Medicare procedure has been so aggressively marketed by so many different components of the health care community.

The major players—physicians, surgical facilities, manufacturers, distributors and salespersons—drive the marketing.

Ophthalmologists compete for patients by openly advertising their services on radio, TV and in newspapers, and offering inducements such as no-cost surgery, free transportation, and free lunch following surgery. Some of the highest volume physicians own and operate specialized centers devoted exclusively to cataract surgery and fully equipped with state-of-the-art technology.

Hospitals are moving aggressively to maintain their relative market share by advertising directly to the elderly. Like physicians, some offer free surgery by waiving the Medicare coinsurance and deductibles. Recent shifts to outpatient settings put hospitals in direct competition with ambulatory surgical centers and physicians who operate in their offices.

Lens and Equipment Manufacturers are competing aggressively for sales and market domination. Large discounts are common and include equipment rebates or credits. Free trips and training are almost routine exchanges for lens purchases. Instances have been reported of offers to deposit kickbacks in foreign banks. Ophthalmologists are even offered commissions for lens sales to hospitals.

Although these intense marketing activities have sometimes resulted in improved products and reduced costs, the savings have not been passed on to the federal government, which pays more than $500 million annually in unnecessary Medicare expenditures for cataract surgery.

THE BENEFICIARY'S EXPERIENCE

For the beneficiary, cataract removal and IOL implant is a literal miracle. Surgery is simple and relatively painless. Hospitalization is normally unnecessary and recovery is brief. The cost is frequently minimal and vision is improved or restored.

OIG staff talked to 93 beneficiaries during the inspection. Most expressed an overwhelmingly positive reaction to the results of their cataract surgery. Typical comments were:

> -"It's marvelous and so easy to go through." -"I'd recommend it to anyone with a problem." -"I'm so happy — I can even read without my glasses now."

A few people, although satisfied with the results, encountered complications such as glaucoma. Fewer than 4% were dissatisfied with their surgical experience.

Most of the patients recovered quickly from surgery, went home within a few hours and resumed normal activity almost immediately. One man returned to work the following day.

The typical setting for their surgery was outpatient—most commonly a hospital outpatient clinic. Some beneficiaries reported that doctors have told them that Medicare will not allow patient hospital admissions for cataract surgery. This misconception resulted in such beneficiary comments as "I'm violently opposed to the Medicare restriction that surgery has to be outpatient. The U.S. government has no business setting the conditions under which a doctor can operate or which dictate where a doctor can operate. I can't see clearly and think it is because the doctor had to hurry to finish the surgery in the outpatient setting."

In most cases, however, Medicare beneficiaries are well aware of their options for cataract surgery. Ophthalmologists distribute educational pamphlets, give talks at senior citizen centers and stress patient education. During surgery, they even allow relatives to observe the actual procedure on closed-circuit TV.

Beneficiaries' out-of-pocket expenses for cataract surgery vary greatly. In this sample, half said they paid nothing, but most had supplemental insurance whose premiums must be taken into account. These premiums frequently total $1400 or more a year. Few beneficiaries said Medicare, solely or in combination with Medicaid, paid for everything. Total payments (in addition to Medicare and supplemental insurance), varied greatly, most commonly about $1000 but as high as $2500. Several persons were distressed about the extraordinary charges. As one said, "I'm not happy about having to pay extra for the anesthesiologist." Another stated, "Cataract surgery is too costly. I worked at the Medical Center 16 years, and I know the costs are too high."

Beneficiary opinions and comments supported conclusions drawn by the OIG. The benefits are remarkable, the medical practice is patient oriented, but costs are often excessive.

SURGICAL SETTINGS DICTATE CURRENT MEDICARE PAYMENTS AND BENEFICIARY LIABILITIES

Complex Medicare reimbursement principles and policies result in wide payment variations among the four settings for cataract surgery. Even within a given setting there are marked differences. A description of these complexities explains why excessive Medicare payments can occur.

REIMBURSEMENT POLICIES

Services associated with cataract surgery are reimbursed by the Medicare program based on Diagnostic Related Group (DRG) rates for inpatient hospital services, reasonable cost determinations for outpatient hospital services, reasonable charge allowances for physician services and fixed rates for Ambulatory Surgical Centers (ASC). The total payment for any patient receiving cataract surgery will almost always include at least two of these methodologies; the only exception is when a physician performs the surgery in his office and his office has not been certified as an ASC. (In this case, he would not receive a facility fee.)

PHYSICIAN FEES

Cataract surgery always includes a physician professional component which is reimbursed by Medicare under the reasonable charge methodology. The payment is made directly to the beneficiary unless the doctor has accepted assignment. If the doctor does not accept assignment, he may bill and receive payment from the beneficiary for his total charge. If the doctor accepts assignment, he can collect only the difference between the Medicare payment and the Medicare allowance, plus any outstanding annual deductible ($75). Under most circumstances, Medicare pays 80 percent of the reasonable charge allowance. One major exception is when cataract surgery is performed on an outpatient basis; if the doctor accepts assignment, he receives 100 percent of the reasonable charge determination and the beneficiary is not liable for any coinsurance or deductible. The physician may charge a separate fee for the IOL except when the surgery has been performed during an inpatient hospital stay. The IOL is always reimbursed at the 80 percent rate.

FACILITY FEES

In addition to the payment for the physician's service, Medicare will pay:

- Hospital Inpatient—A Prospective Payment DRG-39 rate based on a three-day stay, including all facility services, the IOL and other supplies. The hospital can collect only the Medicare hospital deductible from the beneficiary.

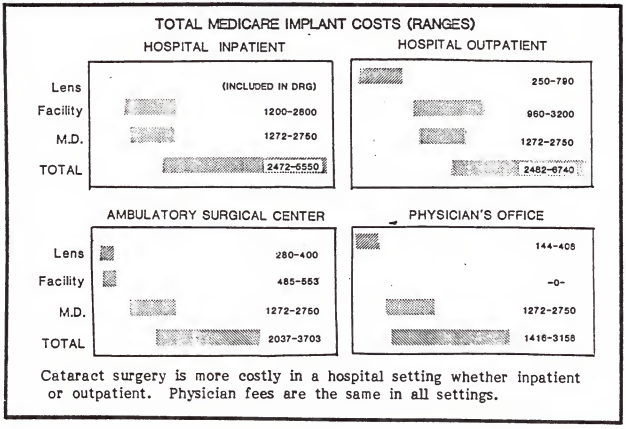
- Hospital Outpatient—A percentage of cost to charges based on a cost report audit by the hospital's fiscal intermediary. The charges may or may not include the IOL and the hospital can collect 20 percent of its charges from the beneficiary.

- Ambulatory Surgical Center—A fixed fee for all facility services which does not include the IOL. The ASC receives 100 percent of the reasonable charge allowance and the beneficiary pays no coinsurance or deductible. The IOL charge is subjected to a reasonable charge determination and the ASC can bill the beneficiary for the difference between the Medicare allowance and payment.

Within a given setting, Medicare payment is determined by the physician's diagnosis or the procedure performed. However, the actual facility payments for the same treatment differ from one setting to another. Medicare payment is not adjusted to the payment actually made to the provider in the least expensive setting.

COMPARATIVE COSTS AMONG SETTINGS

This inspection finds that the total cost of cataract surgery involving one eye can be as little as $1,416 or as much as $6,740. The charts below present the breakdown of costs among different settings.



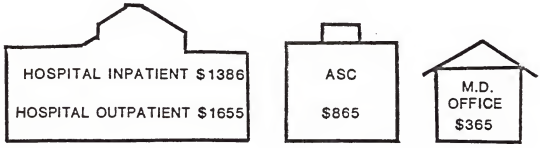
Cataract surgery is more costly in a hospital setting whether inpatient or outpatient. Physician fees are the same in all settings.

Since Medicare will not pay a physician a separate facility fee when the surgery is performed in the non-certified office surgical suite, this is the least expensive setting for the program; however, it is also the least common. Sixteen of the ophthalmologists in the sample chose to perform the surgery in their non-certified surgical suite where the only facility fee to be collected was directly from the patient. A disproportionate number of physicians who perform surgery in non-certified surgical suites were included in the sample since the sample was drawn from physicians and ASCs who billed for lenses and, typically, hospitals supply lenses when the surgery is performed in their outpatient departments. Other physicians, faced with the inability to receive Medicare payments for their non-certified facilities, choose to perform the operation in the outpatient department of the hospital.

Of all the certified settings for cataract surgery, the ambulatory surgical center is the least expensive to the Medicare program. Even when the IOL reimbursement equals that paid to the highest priced physician, the total facility and lens cost averages $865, compared to a hospital outpatient department average of $1,655.

The following chart shows average Medicare payments for facilities and lens in the four settings.

AVERAGE MEDICARE PAYMENTS FOR FACILITY AND LENS



HOSPITAL COSTS BY STATE

Hospital outpatient Medicare reimbursement in five of the states in the inspection indicates significant differences and ranges for cataract surgeries with intraocular lens implants. Not only does the Medicare reimbursement vary significantly among states, but there was a significant range within each state. Almost every hospital received reimbursement for outpatient surgeries that exceeded the DRG-39 inpatient Medicare reimbursement rate.

COMPARISON OF HOSPITAL OUTPATIENT
MEDICARE REIMBURSEMENT TO DRG-39 INPATIENT REIMBURSEMENT
BY STATE REVIEWED

State	Outpatient Reimbursement	DRG-39 Inpatient Reimbursement
California	$1,286-3,251	$1,550-2,400
Florida	1,200-2,224	820-1,270
Pennsylvania	1,143-1,851	1,100-2,800
Texas	1,156-1,818	800-1,800
Washington	960-1,634	900-1,300

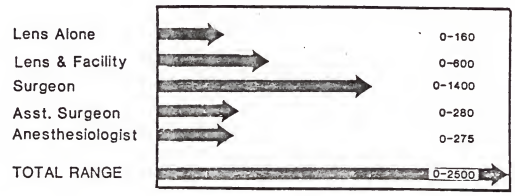
COST TO BENEFICIARIES

For beneficiaries, the outpatient department of the hospital is the most expensive place to have cataract surgery if the hospital collects coinsurance. However, this inspection found that many hospitals are waiving coinsurance to compete with ASCs. Some hospitals have developed an outpatient surgery schedule of rates. These rates are billed to Medicare on an interim basis and the beneficiary coinsurance amount is calculated as 20% of the fixed rate. This reduces the beneficiary's liability, but has no effect on actual Medicare reimbursement. All costs associated with the outpatient department will be included on the hospital's cost report without regard to the schedule of rates and a Medicare payment adjustment will be made to reflect these costs.

Some hospitals are also waiving hospital insurance deductibles for Medicare cataract patients who have the surgery as inpatients. Advertising by at least two major hospital chains includes such offers.

Approximately 50 percent of the beneficiaries in the inspection sample paid no out-of-pocket expenses. For those who do pay, the amount can be significant. At the extreme, this can total as much as $2,500. The chart illustrates the range of specific charges associated with cataract surgery.

RANGE OF BENEFICIARY COSTS



Beneficiaries are paying less because of the competition for patients and because Medicare's outpatient surgery regulations eliminate coinsurance and deductibles. Nevertheless, while many beneficiaries frequently pay nothing towards the surgical fee or the facility, they can incur expenses for coinsurance associated with the anesthesiology service, the assistant surgeon or the intraocular lens.

As indicated above, beneficiaries may still be faced with out-of-pocket expenses totalling up to $2,500 when the surgeon does not accept assignment, the hospital outpatient department charges coinsurance (20 percent of amount billed to Medicare) and there is no supplementary insurance.

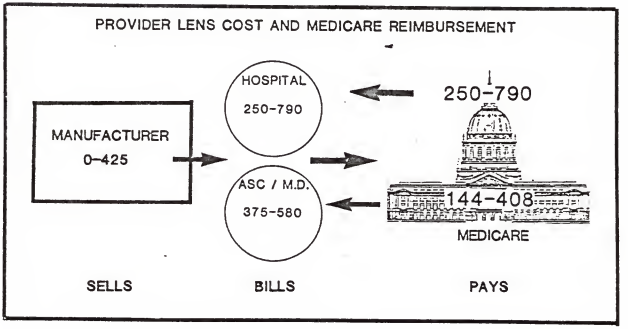
REIMBURSEMENT POLICIES PERMIT EXCESSIVE PAYMENTS

OPEN-ENDED LENS PAYMENTS ACCOMMODATE INFLATED PRICES

Lenses cost $35 to $50 to manufacture. The average list price for a lens is $325. Ultraviolet filters and laser ridges add about $75 to this list price.

Although discounts on list prices are a recent phenomenon in the U.S., the prices manufacturers charge for lenses in foreign countries have always been consistently lower. In Canada, U.S. manufactured lenses are readily available for under $200, while in England and other European countries the lenses sell for $125 or less.

High volume users of IOLs have been willing to pay the list prices knowing that Medicare's reasonable cost or charge determination will readily accept the prices without applying any prudent buyer requirement. Furthermore, ASC rates do not include the IOL which is reimbursed on a reasonable charge basis and can add considerably to the ASC's revenues.



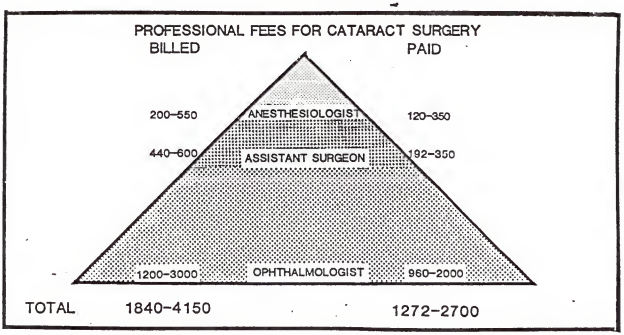
The minority of hospitals, ophthalmologists, and ASCs who have bargained with IOL manufacturers or put lenses out for bid have found that lenses they formerly purchased for over $300 can now be bought for $150 or less. Hospitals that participate in consortium purchase arrangements for other supplies are just beginning to consider IOL purchases as part of these arrangements.

In the inspection sample, such discounts were not passed on to the Medicare program. Providers continue to bill their pre-discount price which will result in Medicare paying more than $100 million in 1985 in unnecessary costs for lenses alone.

OPHTHALMOLOGIST FEES MAY NOT REFLECT TECHNOLOGICAL STREAMLINING

The performance of cataract surgery has changed significantly with the development of advanced surgical techniques, sophisticated equipment and medical settings geared for specialized procedures. The knowledge and skill of the ophthalmologist is now executed in minutes rather than hours, using a local rather than a general anesthetic, in an outpatient setting rather than in a hospital. This occurs with less risk and discomfort to the patient. Despite this technological "streamlining", the fees have actually increased.

An examination of the relationship between surgical time and Medicare payment defines one of the major reasons why costs are exorbitant. Standard surgeries without complications now take 20 to 30 minutes. A surgeon may now perform as many as 10 to 15 operations in a day. For this, there is a surgeon's fee of $1,200 to $3,000 for each procedure. Medicare reimbursement, as found in the sample, is $960 to $2,000 per surgery. Non-certified facility fees, which are not paid by Medicare, and coinsurance are often added to this amount.



Directly stated, this inspection found the fees of some ophthalmologists to be excessive. Ten of the thirty-eight ophthalmologists were paid between $1 million and $6.4 million in 1984. Each of the states in the sample had its Medicare millionaires. Inflated surgery costs are attributable to ophthalmologists charging too much and Medicare paying too much. Neither the medical profession nor Medicare has acknowledged these technological advances and efficiencies by reducing the charges or payments associated with cataract surgery.

Some physicians, who complained about losing money because Medicare would not allow a facility fee for their non-certified surgical suites, still chose to perform the surgery in their own offices rather than resort to using the outpatient department of the hospital. Since these physicians were among the Medicare millionaires, it is fair to assume that the Medicare surgical reimbursement amount was more than adequate to offset the losses attributed to non-reimbursable facility fees which normally include all supplies and disposables used in the surgery.

High-tech equipment used in connection with cataract surgery is expensive. For example, a YAG laser, which is used to treat the minority of cataract patients who develop secondary cataracts (a clouding of the posterior capsule after implant which is treated by piercing the capsule surgically or with a laser beam), costs in excess of $60,000. Rather than use someone else's YAG, or pool resources, each high volume ophthalmologist purchases his own knowing that the inflated Medicare reimbursement will pay for the cost of the equipment. Some ophthalmologists charge as much as $1,000 for the YAG procedure, which takes less than 15 minutes and involves no manual incision, operating room, or additional supplies. Although the Medicare payment may only be $500, these excessive charges will eventually be recognized by the program under the existing reasonable charge methodology. Thus, Medicare will accept these charges as appropriate and they will become institutionalized.

SHIFTING SURGERY TO OUTPATIENT DEPARTMENTS DOESN'T BRING EXPECTED SAVINGS

A popular perception is that surgery in a hospital outpatient department is far less costly to Medicare than when performed in an inpatient setting. This inspection found this to be generally inaccurate. In fact, hospital outpatient costs can equal or exceed those for inpatient hospital stays because program reimbursement for hospital outpatient departments is not subjected to any limitation similar to a DRG rate or fixed ASC rate. By shifting costs to the outpatient department, hospitals can increase their Medicare revenues.

Hospital outpatient bills include charges for the operating room and the recovery room, as well as supplies and disposables which accompany cataract surgery. These supplies and disposables are subjected to the hospitals' usual mark-up, which may be as high as 80 to 100 percent. When these same supplies are used in an ASC, they are included in the fixed rate and the Medicare program does not acknowledge these mark-ups in actual program payments. This inspection found that some of the hospitals with the highest mark-up were being reimbursed by Medicare at 100 percent of their charges.

In almost all cases, the hospital outpatient charges are higher than the DRG rate for cataract surgery. This does not always mean that Medicare pays more for the surgery when it is performed in the outpatient department, but this can and will happen if Medicare continues to apply the reasonable cost concept to outpatient services.

SEPARATE PAYMENTS TO ASSISTANT SURGEONS AND ANESTHESIOLOGISTS DISCOURAGE USE OF QUALIFIED TECHNICIANS AND NURSES

Medicare recognizes and pays separate charges for assistant surgeons and anesthesiologists who participate in cataract surgery. The assistant surgeon payment is usually 20 percent of the surgeon's fee, while the anesthesiologist is paid base units plus time units.

An assistant surgeon fee can be as high as $700, with a maximum Medicare payment of $560. Ophthalmologists interviewed in the inspection agreed that the role of the assistant surgeon could be adequately performed by either an ophthalmology technician or a trained nurse. However, very few surgeons are using technicians or nurses because Medicare will not pay separately for their services. The salaries of the technicians or nurses would have to come out of the surgeon's payment.

The findings in the inspection mirror those of a recent report by the audit section of the OIG. That report recommends that the services of assistant surgeons during cataract surgery should not be paid by Medicare unless there is clear and specific medical justification for their presence. The Office of Audit recommendation has been incorporated in section 147 of the budget reconciliation Act of 1985. Excluding payments for assistant surgeons will save Medicare at least $40 million annually.

Anesthesiology during cataract surgery primarily consists of a local anesthetic administered by injection by the surgeon. General anesthesia is rarely used. This reduces the role of the anesthesiologist to administering intravenous solutions and monitoring vital signs—tasks that can be, and often are, performed by certified nurse anesthetists. In states such as Texas, it is common for anesthesiologists to employ nurse anesthetists (CRNAs) to carry out these responsibilities. California anesthesiologists, on the other hand, rarely employ CRNAs because there are a sufficient number of anesthesiologists willing to perform these standby services. In either case, Medicare payment is separate from the surgeon's and adds considerably to the total cost of cataract surgery for the program.

Current fees for anesthesiologists involved in cataract surgery are up to $550, with Medicare paying a maximum of $440. It is estimated that 1985 Medicare payments to anesthesiologists for services associated with cataract surgery will be in excess of $156 million.

PROPOSED CHANGES

RECOMMENDATION #1

ISSUE: Excessive costs are being incurred by both the Medicare program and beneficiaries for cataract implant surgeries performed in hospital outpatient departments. In this inspection, the average reimbursement for outpatient hospital services exceeded the DRG payment by $269. Some hospitals received as much as $1200 more than their DRG payment. Compared to the fixed rate for ASC cataract surgeries, hospitals receive an average of $790 more than surgical centers.

RECOMMENDATION: LIMIT HOSPITAL OUTPATIENT FACILITY FEES AND BENEFICIARY CHARGES TO APPROXIMATE MEDICARE PAYMENTS AND CHARGES NOW AUTHORIZED FOR AMBULATORY SURGICAL CENTERS.

IMPACT: It is estimated that the Medicare program could have saved over $143 million in 1985 if outpatient hospital reimbursement had been limited to the amount a hospital receives under its DRG payment for cataract surgery. Even more savings, up to $419 million, could have been realized if the hospital outpatient department payment had been the same as the fixed rate for ASCs.

Beneficiary expenses for services received in the outpatient department should be commensurate with those incurred for ASC services. The hospital would receive 100% of the established rate and no deductible or coinsurance could be billed to the beneficiary.

HCFA RESPONSE: HCFA believes it would be inappropriate to use the ASC rate as a limit for hospital outpatient departments because the rate has not been updated in three years. The OIG supports any initiatives, including the redetermining of ASC rates, which would facilitate the establishment of a limit on the payments to hospitals for outpatient cataract surgery. It is critically important that Medicare reimbursement policies provide an equivalent reimbursement irrespective of setting to address the inequities found in this inspection.

RECOMMENDATION #2

ISSUE: Medicare reimbursement principles neither require nor encourage providers to obtain lenses at the lowest available price. The average Medicare reasonable charge payment to an ophthalmologist or an ASC for an IOL is $365. This inspection found that discounts were available from major manufacturers and that lenses could be purchased for one half to one third the average price.

RECOMMENDATION: ESTABLISH A NATIONAL CAP (BASED ON A GENERIC PRUDENT BUYER CONCEPT) FOR LENS PAYMENTS WHEN LENSES ARE BILLED SEPARATELY.

IMPACT: Over $31 million would have been saved in 1984 if the Medicare lens payment had been capped at $200. If the cap had been $150, over $40 million would have been saved. While this inspection does not recommend that $200 (or $150) be the established cap, this figure is considered conservative given the inspection findings. The future impact of this recommendation will become even more significant because of the continued shift of cataract surgery to ASCs and physicians' offices where lenses are billed separately.

HCFA RESPONSE: HCFA concurs with the recommendation and has issued instructions to Medicare carriers stressing inherent reasonableness. On February 18, 1986, HCFA published a proposed rule which will permit special payment limitations. This rule will give HCFA expanded authority and will provide the foundation for promulgating a national cap for intraocular lens payments.

RECOMMENDATION #3

ISSUE: Medicare permits the services of assistant surgeons and anesthesiologists to be billed and paid separately thus reducing the incentive to utilize less costly but qualified and proficient technicians and nurses. Use of both physicians can add as much as $1,000 to the cost of individual cataract surgery. The OIG issued an audit report on June 7, 1985, entitled "Review of Medicare Payments for Assistant Surgeon Services During Cataract Surgery", in which it is recommended the services of an assistant surgeon be excluded from Medicare reimbursement for routine cataract surgery. Although ophthalmologists require assistance during cataract surgery, such assistance can usually be provided by a surgical technician or an operating room nurse.

RECOMMENDATION: PAY A SINGLE PROFESSIONAL FEE TO COVER ALL PROFESSIONAL STAFF ASSOCIATED WITH CATARACT SURGERY.

IMPACT: Estimated annual savings are at least $40 million if payments are excluded for assistant surgeons and an additional $150 million or more if payments for anesthesiology services are excluded.

The surgeon could continue to use assistant surgeons and anesthesiologists rather than less costly technicians or nurses. However, their fees would have to be paid by the surgeon from the single Medicare payment he receives, unless prior approval had been obtained. Prior approval would be given only if medical necessity could be substantiated.

HCFA RESPONSE: HCFA agrees that there is a need to curtail excess payments for anesthesiology and assistant surgeon services for cataract surgery.

Instructions have been issued requiring that Medicare carriers use a prepayment screen for billings for assistant surgeons. Medical review will be required before payment is made. Proposed legislation in H.R. 3128 specifically addresses the assistant surgeon issue.

RECOMMENDATION #4

ISSUE: There is currently no mechanism to assess the impact of rapidly changing medical technology on fees charged by physicians for surgical procedures. For this reason the fees do not reflect recent efficiencies. In many cases, including IOL implants, Medicare is paying much more than is necessary to perform the procedure in a manner which is efficient, cost effective and yet conducive to quality patient care. The Prospective Payment Commission carries out this function for inpatient services, but there is nothing comparable for physician services.

RECOMMENDATION: CREATE AN INDEPENDENT COMMISSION TO ASSESS PERIODICALLY THE CHANGES IN SURGICAL PROCEDURES AND TECHNOLOGY AND MANDATE ADJUSTMENTS TO MEDICARE REIMBURSEMENT.

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IMPACT: This Commission would determine appropriate reimbursement based on actual changes in surgical procedures. It would provide a means for HCFA to make rapid adjustments in physician payments for a wide spectrum of surgical procedures. While actual savings cannot be estimated, it is anticipated that this mechanism would be a centerpiece for controlling inflationary medical costs.

HCFA RESPONSE: HCFA opposes the establishment of another independent commission. However, this recommendation had been included in H.R. 3128 as adopted by the Conference Committee.

ESTIMATED SAVINGS

RECOMMENDATION	SAVINGS	
	1 Year (1986)	5 Year ('86 - '90)
Limit Hospital Outpatient Reimbursement	DRG Rate or ASC Rate $220 M 740 M	DRG Rate or ASC Rate 1.17 B 3.7 B
Cap Lens Payment	$150 Cap $74.2 Million	$150 Cap $371 Million
Pay Single Professional Fee	Asst. Surgeon $40 Million Anesthesiologist $260 Million	Asst. Surgeon $200 Million Anesthesiologist $1.3 Billion
Establish Commission	Cannot be estimated	
TOTAL	$594.2 Million to $1.1 Billion	$3 Billion to $5.6 Billion